SECTION 2

ELIGIBILITY ADMINISTRATION

Waiver of Coverage

Waivers will only be accepted:

- during the annual Open Enrollment period;
- from a new employee no later than thirty (30) days of hire date (or date specified by your non-state agency);
- with an appropriate Qualifying Event; or
- at age sixty-five (65) (TEFRA).

To waive coverage, the employee must complete all applicable sections of the health insurance application.

An application to waive coverage must be completed annually; failure to update a waiver will result in Automatic Assignment to the lowest cost Single Option A plan available in the employee's county of residence. Failure to communicate this information to your employees will create problems for your employees that cannot be corrected until the next Open Enrollment period.

Employees who waive coverage because they have coverage under one of the following will be allowed to enroll in an available health plan during a Special Enrollment Period if they can provide written proof that the previous coverage terminated:

- another employer's health benefit plan;
- Military Insurance Coverage (Tri-Care);
- Medicare or Medicaid;
- COBRA (other than for non-payment); or
- State Continuation

An active employee may waive insurance coverage during the plan year when he/she reaches age sixty-five (65) if he/she desires to have Medicare only. (Refer to TEFRA Letter Appendix C-5).

Automatic Assignment

An employee eligible for participation in the Public Employee Health Insurance Program, who fails to do one of the following by the established deadline, will be automatically assigned to the lowest cost Single Option A plan that is available in his/her county of residence.

Failure to complete an application within thirty (30) days of the date of hire (or date specified by the employer agency)

- An employee who does not submit a health insurance application within thirty (30) days of his/her date of hire will be auto-assigned to the lowest cost Single Option A plan available in his/her county of residence.

Failure to complete the required application during Open Enrollment

- An employee who must make a change for the next plan year and who fails to complete an application during Open Enrollment will be auto-assigned to the lowest cost Single Option A plan available in his/her county of residence.

- An employee who has waived coverage and fails to complete a waiver application during Open Enrollment will be auto-assigned to the lowest cost Single Option A plan available in his/her county of residence.

Failure to complete the application, if required, when employee moves out of his/her carrier's service area

- An employee who fails to elect a new carrier within thirty (30) days following a change in residence to a county where his/her carrier is not available, will be auto-assigned at the same level of coverage, to the lowest cost plan available in his/her county of residence. This event will not allow a change in the level of coverage.

  Note: This applies only if the employee marked "home county" when selecting his/her health insurance for the year.

Employees who are automatically assigned are not eligible to direct any portion of the employer contribution to the Health Care Flexible Spending Account.

Refer to Automatic Assignment Chart (Appendix B-5) for in-state and out-of-state automatic assignment. Also, refer to the Automatic Assignment letter (Appendix C-1).

Transition from Dependent to New Employee

A dependent child that is already covered as a dependent in the Public Employee Health Insurance Program and becomes employed by a participating employer, has the following options upon hire:

The Child Becomes a Policy Holder

If, upon hire, a dependent child becomes ineligible for coverage as a dependent under his/her parents' plan, the child:

- must complete a health insurance application as a new hire; and
- will be dropped from his/her parents' plan on the day prior to the effective date of his/her coverage as a policy holder.

The Child Remains a Dependent on his/her Parents' Plan

If, upon hire, a covered dependent still meets the dependent eligibility requirements, the affected parties must do the following:

- the newly hired dependent child must complete a health insurance application to waive coverage; and
- the newly hired dependent child must submit a notarized letter from his/her parent(s), as explained below.
    - The parent, under whom he/she is still covered as a dependent child, must provide the OPEHI with a written request to keep the child enrolled in his/her plan. The request must be notarized and it must state that the child still meets all dependent eligibility requirements of the plan after his/her employment. If the required documentation is not received by the OPEHI with the dependent child's application to waive coverage, the OPEHI will automatically terminate the child's coverage as a dependent and will enroll him/her in his/her own plan (waiver or coverage).

NOTE: If the child being dropped is the only dependent child in the plan, the OPEHI will automatically assign the parent's coverage as follows:

- a Parent Plus plan will be assigned to a Single plan;
- a Family plan will be assigned to a Couple plan; or
- a Family Cross-Reference plan will be assigned to two Single plans.

OPEHI will notify the parent's Insurance Coordinator of this action.

Transfers and Rehires

With break in service less than sixty-three (63) days

An employee who transfers or resigns from any agency or organization within the Public

Employee Health Insurance Program and who does not experience at least a sixty-three (63) day break in service, must be reinstated to his/her prior elections unless he/she has experienced a Qualifying Event or Open Enrollment has occurred. The Insurance Coordinator must complete an Update Form reporting the employee's transfer.

With break in service greater than sixty-three (63) days

An employee who has a break in service greater than sixty-three (63) days is treated as a new employee.

I.D. Cards

- An employee should receive his/her I. D. card(s) within fourteen (14) days of receipt of enrollment information by the health insurance carrier.
- The employee may use a copy of the application for identification until his/her card(s) is received.
- The subscriber's (employee's) Social Security Number is necessary to process claims.
- An employee may request additional I.D. cards by calling the toll-free number for his/her carrier listed in the *Health Insurance Handbook*.

Each carrier will provide the I.D. cards, which will designate the plan type (PPO/ HMO/POS/EPO), as well as member certificates of coverage describing benefits provided by the plan.

Member Certificate of Coverage

Each carrier will distribute certificates of coverage (COC) to all covered members. The COC will describe benefits as well as plan limitations and exclusions. All employees should be encouraged to become familiar with their certificates of coverage at the beginning of the plan year. Knowing what is covered and how to use the health plan correctly is very important.